Effective Contraceptive Use among Women at Risk of Unintended Pregnancy Guidance Document

Oregon Health Plan

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Contents

Introduction

The purpose of this document is to provide Coordinated Care Organizations (CCOs), Oregon clinics, providers, and administrative staff with guidance on the effective contraceptive use among women at risk of unintended pregnancy measure, including strategies for addressing pregnancy intentions and increasing effective contraceptive use, and measure specifications for 2015. This document will be updated as appropriate to reflect any changes in policy and regulation.

Executive Summary

For women and adolescents between the ages of 15 and 50, reproductive health care is an essential part of their overall health care. For many women, reproductive health concerns are the only reason they seek routine medical care. The average American woman who wants two children spends three to five years trying to conceive, being pregnant, postpartum and breastfeeding, and three decades trying to avoid pregnancy.

Almost 50 percent of pregnancies in Oregon are unintended, and have been for more than three decades. Among women with an unintended pregnancy, 43 percent reported using contraception, but they were using it incorrectly or inconsistently. Fifty-two percent reported using no contraception method at all. This suggests that most women are at risk of unintended pregnancy and are in need of contraception counseling in order to find a method that meets their needs. Most women would benefit from knowing which methods of contraception are the most effective.

Coordinated Care Organizations and providers across Oregon can improve health and reduce unintended pregnancies by implementing pregnancy intention screenings and providing effective contraceptives to women who do not wish to become pregnant. This document provides additional information on pregnancy intentions, the One Key Question® initiative, and health plan and clinic level strategies for improving effective contraceptive use.

For the third measurement year, CY 2015, the CCO incentive measure specifications focus on women ages 18-50 who are not currently pregnant and who adopted or continued use of one of the most effective or moderately effective contraceptives. Note while OHA will report on both adults and adolescents, CCOs will only be incentivized for the adult (ages 18-50) population.

Denominator: All women ages 18-50 who were continuously enrolled in a CCO for the 12-month measurement period. Women who are not capable of becoming pregnant and women who were pregnant during the measurement year are excluded from the denominator.

Numerator: All women in the denominator with evidence of one of the following methods of contraception during the measurement period: sterilization, IUD / IUS, implants, contraception injection, contraceptive pills, patch, ring, or diaphragm.

Acknowledgements

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- Oregon Health Authority – Public Health Division's Reproductive Health Program
- Oregon Preventive Reproductive Health Advisory Council

Background

For women and adolescents between the ages of 15 and 50, reproductive health care is an essential part of their overall health care. For many women, reproductive health concerns are the only reason they seek routine medical care. The average American woman who wants two children spends three to five years trying to conceive, being pregnant, postpartum and breastfeeding, and three decades trying to avoid pregnancy.

Healthy People 2020, the 10-year national goals for improving the health of all Americans, includes several objectives related to contraceptive use as a core preventive health service: [1]:

- FP-1: Increase the proportion of pregnancies that are intended.
- FP-5: Reduce the proportion of pregnancies conceived within 18 months of a previous birth.
- FP-6: Increase the proportion of females at risk of unintended pregnancy or their partners who used contraception at most recent sexual intercourse.
- FP-8: Reduce pregnancies among adolescent females.
- FP-11: Increase the proportion of sexually active persons ages 15-19 years who use condoms and hormonal or intrauterine contraception to both effectively prevent pregnancy and provide barrier protection against disease.

The Patient Protection and Affordable Care Act (ACA) of 2010 has a major focus on improving preventive care services to individuals of all ages and genders. The U.S. Department of Health and Human Services charged the Institute of Medicine (IOM) with reviewing what preventive services are important to women's health and well-being. In its report "Clinical Preventive Services for Women: Closing the Gaps", the IOM recommended that preventive services for women include "a fuller range of contraceptive education, counseling, methods, and services so that women can better avoid unwanted pregnancies and space their pregnancies to promote optimal birth outcomes."[2]

[1] Healthy People 2020: https://www.healthypeople.gov/2020/topics-objectives/topic/family-planning

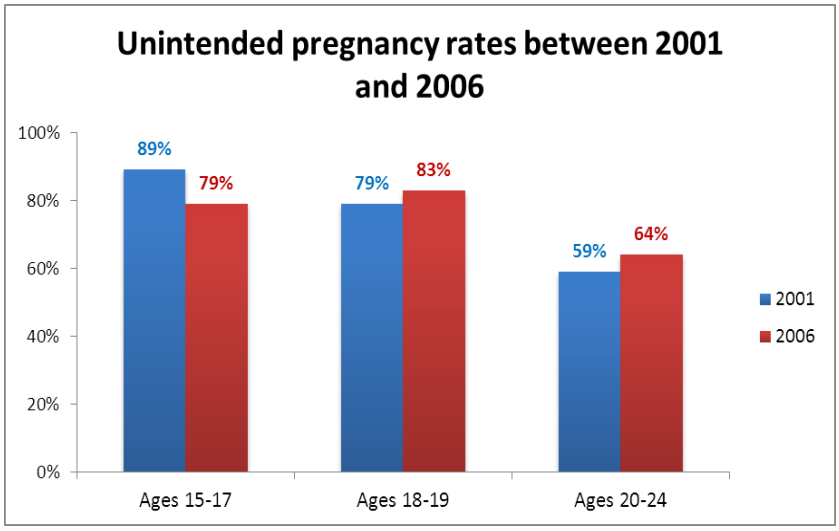
[2] Institute of Medicine. 2011. *Clinical Preventive Services for Women: Closing the Gaps* http://www.iom.edu/Reports/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps.aspx

Unintended Pregnancies

Almost 50 percent of pregnancies in Oregon are unintended, and have been for more than three decades.[3] In 2011, the most recent year for which we have state-level data on pregnancy intentions, there were 45,136 births, 37 percent of which were considered unintended, and 9,567 elective abortions, for a resulting unintended pregnancy rate of 48 percent.[4,5] A study published in 2013 found that approximately 63 percent of unintended births in Oregon were paid for by Medicaid.[6]

Nationally:

- Forty-nine percent of all pregnancies in 2006 were unintended, a slight increase from 48 percent in 2001.
- Among women ages 19 years and younger, more than 4 out of 5 pregnancies were unintended.
- The proportion of unintended pregnancies are highest among teens younger than 15 years, with 98 percent of these pregnancies being unintended.[7]



[3] Finer, L and Kost K, *Unintended Pregnancy Rates at the State Level*, Perspectives on Sexual and Reproductive Health, 2011, 43(2):78-87.

[4] Oregon Vital Statistics Annaul report 2011, Volume 1. https://public.health.oregon.gov/BirthDeathCertificates/VitalStatistics/annualreports/11v1/Pages/index.aspx

[5] Oregon Pregnancy Risk Assessment Monitoring System, 2011 results. https://public.health.oregon.gov/HealthyPeopleFamilies/DataReports/prams/2011/Pages/feelpreg4.aspx

[6] Sonfeld A and Kost K, Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy and Infant Care: Estimates for 2008, New York: Guttmacher Institute, 2013. http://www.guttmacher.org/pubs/public-costs-of-UP.pdf

[7] http://www.cdc.gov/reproductivehealth/unintendedpregnancy/

Unintended Pregnancy in the United States: incidence and disparities, 2006. Contraception. 2011; 84(5):478-485. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3338192/

Unintended pregnancies disproportionately affect poor women, whose rates of unintended pregnancy are 5.5 times higher than higher-income women. Similarly, African American and Hispanic women have rates two to three times higher than whites, and women who did not graduate high school are 2.3 times more likely to have an unintended pregnancy than college graduates. [8] It is important to provide women at higher risk of unintended pregnancy with contraceptive options and improve their access to reproductive health services.

For women whose unintended pregnancies are unwanted, approximately forty percent end in abortions, the remainder result in births.[9] For these families, an unintended and unwanted pregnancy can lead to an increased likelihood of complications for both the mother and infant. Women with unintended pregnancies that chose to continue the pregnancy are more likely to receive inadequate or delayed prenatal care and have poorer health outcomes such as infant low birth weight, infant mortality, and maternal mortality and morbidity.[10]

Giving birth during adolescence has been linked with increased medical risks and emotional, social, and financial costs. Becoming a teen mom affects whether the adolescent finishes high school, goes to college, and the type of job she will get, especially for younger teens ages 15-17. [11, 12, 13,14]

Women and adolescents who carry an unwanted pregnancy to term and give birth may also have their education or jobs derailed by the pregnancy. The family may be pushed (further) into poverty and the children of those pregnancies face higher rates of abuse and neglect. This in turn may lead to school

[8] Finer and Zolna. Unintended pregnancy in the United States: Incidence and disparities. 2006. *Contraception* 2011 Nov;84(5),478-485.

[9] Finer and Zolna. Shifts in Intended and Unintended Pregnancies in the United States, 2001-2008. American Journal of Public Health, 2014; 104:S43-S48 (see page S44, results section)

[10] Gispon JD, Koenig MA, Hindin MJ. The effects of unintended pregnancy on infant, child, and parental health: a review of the literature. Stud Fam Plann 2008 Mar;39(1):18-38.

[11] Manlove J, Terry-Humen E, Mincieli L, Moore K. Outcomes for children of teen mothers from kindergarten through adolescence In: Hoffman S, Maynard R, eds. Kids having kids: economic costs and social consequences of teen pregnancy. Washington, DC: The Urban Institute Press; 2008.

[12] Hoffman S. By the numbers: the public costs of teen childrearing. Washington, DC: The National Campaign to Prevent Teen Pregnancy; 2014. https://thenationalcampaign.org/why-it-matters/public-cost

[13] Perper K, Peterson K, Manlove J. Diploma Attainment Among Teen Mothers. Child Trends, Fact Sheet Publication #2010-01: Washington, DC: Child Trends; 2010.

[14] Hoffman SD. Kids Having Kids: Economic Costs and Social Consequences of Teen Pregnancy. Washington, DC: The Urban Institute Press; 2008.

failure, behavioral problems, and substance abuse. There may be increased rates of family stress and family violence. [15]

Preconception Health

It is important to note that not all unintended pregnancies are unwanted pregnancies. Sometimes an unintended pregnancy is a welcome surprise. Even in these cases, the fact that the pregnancies were unintended and unexpected means that there were missed opportunities for preconception care.

Adding pregnancy intention screening to routine visits (see Strategy 1 below) will improve the health of all babies born in Oregon, and will increase provider awareness of a woman's intent to become pregnant as a key opportunity to intervene for her health.

The U.S. Preventive Services Task Force (USPSTF) has many recommendations for women of childbearing years who are not pregnant. These tests are recommended as a routine part of a woman's well visit. Recommended women's health services include:

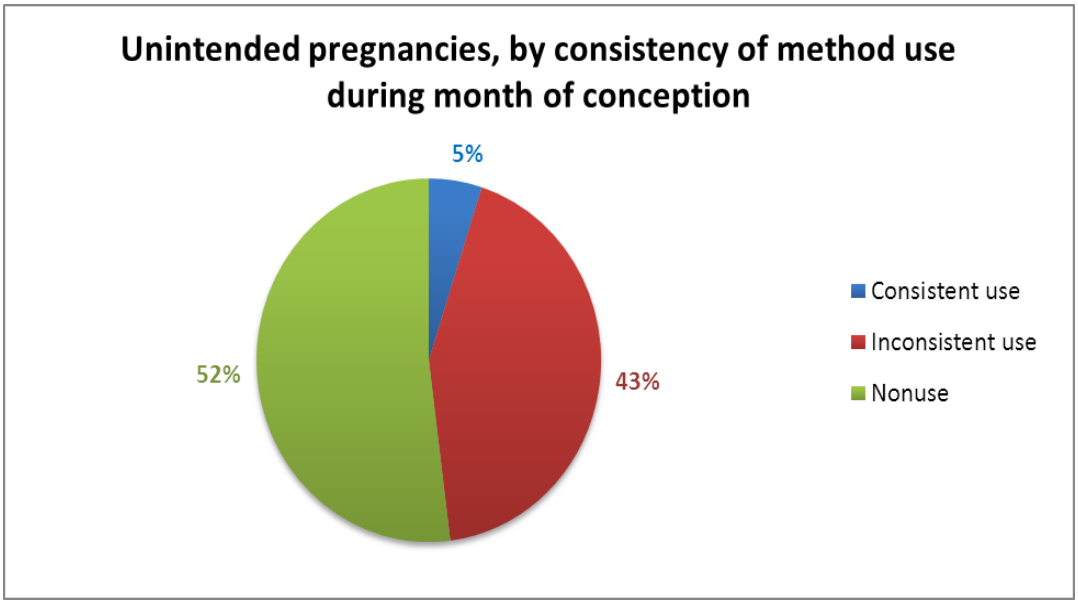
- Screening for high blood pressure in adults ages 18 years and older.
- Screening for sexually transmitted diseases, including cervical cancer, chlamydia and gonorrhea, and HIV) for sexually active women.
- Counseling for sexually transmitted infections;
- Screening and follow up for depression;
- Screening for intimate partner violence;
- Tobacco use screening;
- Obesity screening; and
- Folic acid supplementation

Another key screening for preconception health is an assessment of current medications and chronic health conditions. If a woman is taking medications that can disturb the development of an embryo or fetus, using substances like alcohol or tobacco known to harm a fetus, or has a medical condition that is not well controlled -- her pregnancy and her baby are at unnecessary risk. In these cases, awareness of a woman's pregnancy intentions provides an opportunity for preconception care and counseling, immunizations, and folic acid supplementation to ensure the woman and the pregnancy are as healthy as possible.

[15] Brown SS and Eisenberg L, eds., *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families*, Washington, DC: Institute of Medicine, 1995.

Contraceptive Use

Data from the Guttmacher Institute shows that among women with an unintended pregnancy, 43 percent reported using contraception, yet used it incorrectly or inconsistently. Fifty-two percent reported using no contraceptive method at all.[16]



Nearly one in five (19 percent) sexually active women ages 15-44 who say they do not want to get pregnant report that they are not using contraceptives.[17] This suggests that most women are at risk of unintended pregnancy and are in need of contraception counseling in order to find a method that meets their needs. Most women would benefit from knowing which methods of contraception are the most effective.

Effective Contraceptive Use

Contraceptive methods are ranked by tier.

- Tier 1 methods have the highest effectiveness with failure rates of less than one percent. Tier 1 methods include intrauterine devices (IUDs), implants, and sterilization. IUDs and implants, the reversible Tier 1 methods, are also referred to as LARCs – long-acting reversible contraception.
- Tier 2 methods are moderately effective, with failure rates between six to 12 percent. Tier 2 methods include the pill, patch, ring, injectable, or diaphragm.

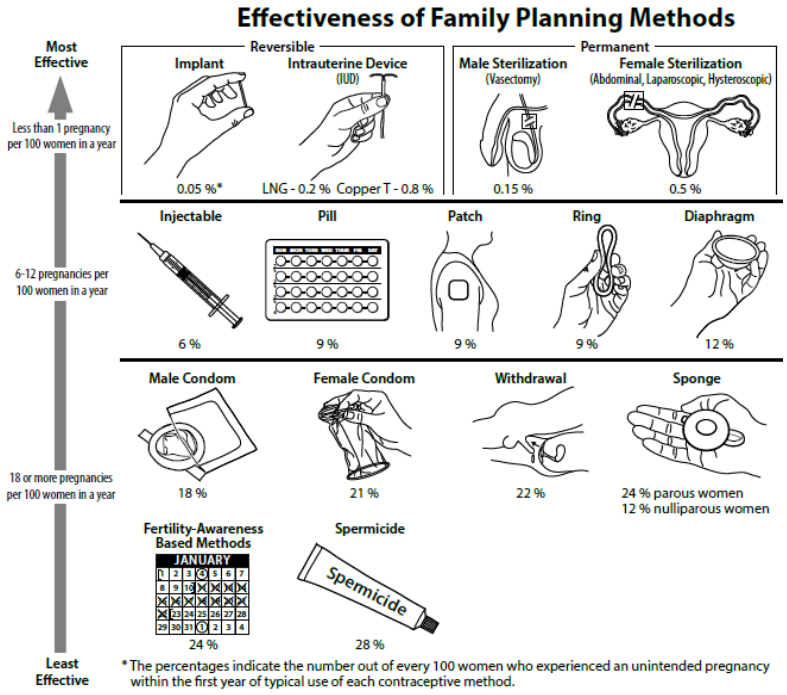
[16] Guttmacher Institute, Fact Sheet: Unintended Pregnancy in the United States, December 2013. http://www.guttmacher.org/pubs/FB-Unintended-Pregnancy-US.pdf

[17] Women and Health Care in the Early Years of the Affordable Care Act: Key Findings from the 2013 Kaiser Women's Health Survey. Kaiser Family Foundation, May 2014. http://kaiserfamilyfoundation.files.wordpress.com/2014/05/8590-women-and-health-care-in-the-early-years-of-the-affordable-care-act.pdf

- Tier 3 contraception includes condoms, sponges, withdrawal, fertility awareness, foam and film. Tier 3 contraception is considered the least effective contraception (with failure rates of 18 percent and higher.

Tier 1 and Tier 2 methods are included in the CCO incentive measure. Tier 3 methods are not (see "Specifications" section below).

Typical Effectiveness of Food and Drug Administrative (FDA)-approved Contraceptive Methods



Adapted from WHO's Family Planning: A Global Hand book for Providers (2001) and Trussell et al (2011).

What is Quality Contraceptive Care?

In the past year, the Centers for Disease Control and Prevention (CDC) has released three guidance documents on family planning to help promote high quality contraceptive care. CCOs and providers can use these documents to provide evidence-based, high quality contraceptive care:

- Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs (http://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf)
- US Selected Practice Recommendations (US SPR) for Contraceptive Use, 2013 http://www.cdc.gov/reproductivehealth/UnintendedPregnancy/USSPR.htm
- United States Medical Eligibility Criteria (US MEC) for Contraceptive Use, 2010 (http://www.cdc.gov/reproductivehealth/UnintendedPregnancy/USMEC.htm)

Together, these guidance documents serve as important resources for all clinicians providing contraceptive care. A more extensive resource list is available at the end of this document.

Potential Barriers to Effective Contraceptive Use

There are many barriers to effective contraceptive use, including:

- Provider assumption that women are getting their reproductive health needs met outside of primary care;
- Limited availability of providers, particularly in rural areas;
- Logistical challenges for members in getting care, such as not being able to take time of work, problems getting child care, and transportation challenges;
- Provider knowledge about the most effective methods of reversible contraception (IUDs and implants), their ability to counsel women about these methods, and their ability to provide them;
- Provider assumption that women are happy with their current contraceptive method;
- Women's knowledge about methods, and specific awareness that IUDs and implants are most effective at preventing pregnancy, with the highest rates of user satisfaction;
- Lack of timely postpartum contraception;
- Cost of the methods when they are not covered by insurance, or only covered in part, or when member is not aware of coverage;
- Lack of confidentiality, often due to an explanation of benefits (EOB) being sent to a member.

Additional factors influencing a woman's use of contraception include cultural and personal attitudes, personal situation, contraceptive use of friends and family, sexual education, and media.

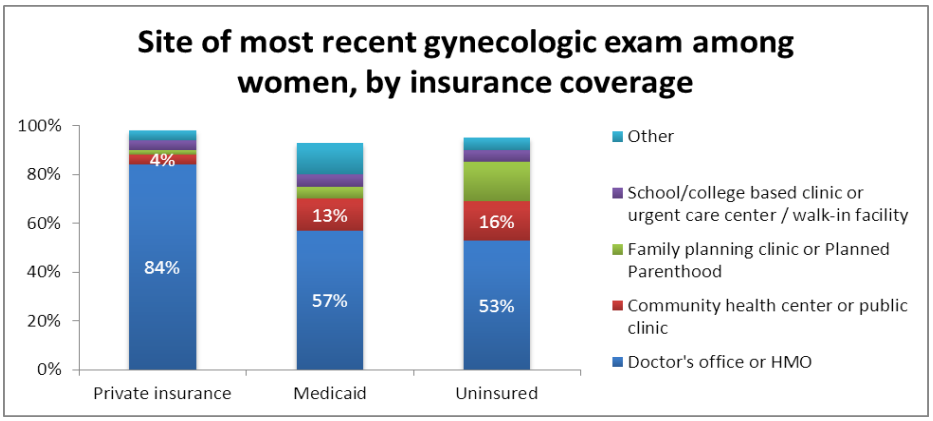
Fragmentation of reproductive health care services

Over the last three decades, the health care delivery system has often been separated between primary care and reproductive health specialists. A common expectation among women is that they must go to two different providers for health care.

Primary care offers reproductive health services when a woman specifically asks; if a woman does not ask, it is often assumed she is being seen by an OB/GYN or family planning specialist outside of primary care. A 2012 study found that almost 60 percent of women had made a health care visit to another provider in the past year, but chose family planning clinics for contraceptive care.[18]

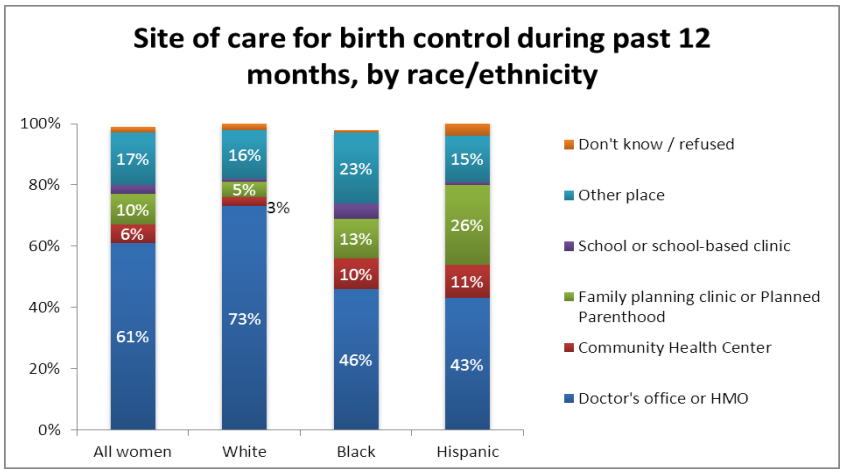
[18] Frost, J, Benson Gold, R, and Bucek A. Specialized Family Planning Clinics in the United States: Why Women Chose Them and Their Role in Meeting Women's Health Care Needs. *Women's Health Issues*, Vol 22(6):e519-525. Nov 2012. http://www.guttmacher.org/pubs/journals/j.whi.2012.09.002.pdf

Nationally, women on Medicaid who have had a gynecologic exam in the past three years (considered a proxy for contraceptive care) are less likely to have had that visit at a doctor's office or with their health plan (HMO), and more likely to have been seen at community health centers or public clinics (13 percent), family planning clinics including Planned Parenthood (5 percent), or at school/college-based clinics or urgent care centers (5 percent). Additionally, younger women (ages 15-24) were more likely to seek care at school-based clinics and urgent care centers / walk-in facilities than at a doctor's office.[19]



Kaiser Family Foundation, 2013 Kaiser Women's Health Survey.

While most women receive their contraceptives from a doctor's office, a significant minority receive their contraceptives from family planning clinics and community health centers. Nationally, reliance on family planning clinics and community health centers is more than twice as high among women of color as for white women.[20]



Kaiser Family Foundation, 2013 Kaiser Women's Health Survey.

[19] Women and Health Care in the Early Years of the Affordable Care Act: Key Findings from the 2013 Kaiser Women's Health Survey. Kaiser Family Foundation, May 2014. http://kaiserfamilyfoundation.files.wordpress.com/2014/05/8590-women-and-health-care-in-the-early-years-of-the-affordable-care-act.pdf

[20] Ibid.

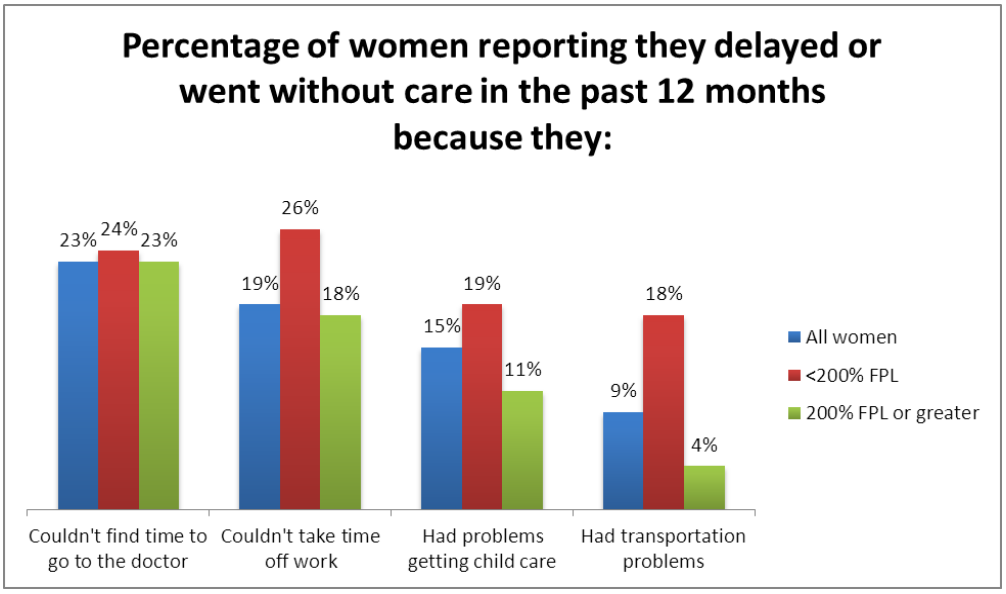
Availability of providers

Nationally, 58 percent of women of reproductive age on Medicaid reported having had a gynecologic or obstetric visit in the past year; however 12 percent of women on Medicaid report that their last visit was more than three years ago and 15 percent of women on Medicaid report they have never seen a provider for OB/GYN care.[21]

In 2012, publicly supported family planning centers met 46 percent of Oregon women's need for contraceptive services and supplies.[22] Although OB/GYN providers may not be as available in rural Oregon as in more populous areas, every county public health department provides Title X family planning services; they are relied-on providers of contraceptive and family planning services for many communities.

Logistical barriers to health care

Lower income women are more likely to report that they delayed or went without care in the past 12 months because of logistical challenges, such as not being able to take time off work, problems with child care, or transportation problems.[23]



Kaiser Family Foundation, 2013 Kaiser Women's Health Survey. Among women ages 18-64.

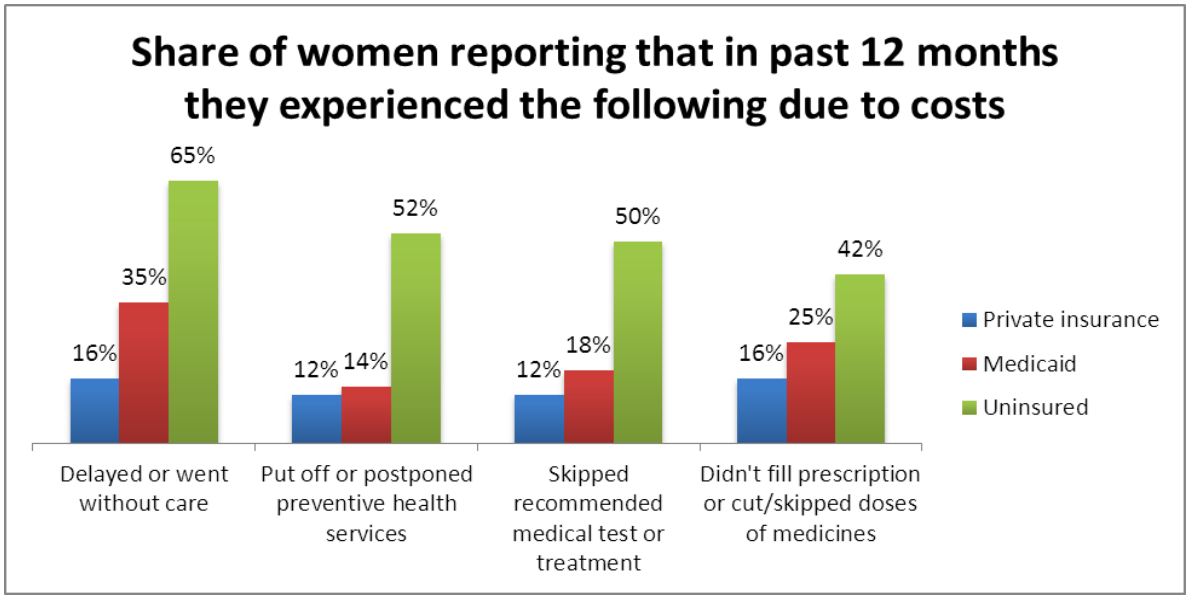
[21] Women and Health Care in the Early Years of the Affordable Care Act: Key Findings from the 2013 Kaiser Women's Health Survey. Kaiser Family Foundation, May 2014. http://kaiserfamilyfoundation.files.wordpress.com/2014/05/8590-women-and-health-care-in-the-early-years-of-the-affordable-care-act.pdf

[22] http://www.guttmacher.org/statecenter/unintended-pregnancy/OR.html and http://www.guttmacher.org/pubs/win/contraceptive-needs-2012.pdf

[23] Women and Health Care in the Early Years of the Affordable Care Act: Key Findings from the 2013 Kaiser Women's Health Survey. Kaiser Family Foundation, May 2014. http://kaiserfamilyfoundation.files.wordpress.com/2014/05/8590-women-and-health-care-in-the-early-years-of-the-affordable-care-act.pdf

Financial Barriers

Nationally, 35 percent of women on Medicaid report delaying or going without care because they could not afford it, and a higher share of women forgo health care needs due to cost compared to men. The cost of contraceptive services and supplies represent a barrier for many women.[24]



Kaiser Family Foundation, 2013 Kaiser Women's Health Survey. Among women ages 18-64.

One study in St. Louis, Missouri sought to address these barriers by providing adolescents with their contraceptive method of choice at no cost, and by emphasizing that IUDs and implants were the most effective methods. Through the Contraceptive Choice Project, 75 percent of adolescents chose to receive either an IUD or an implant after cost and awareness barriers were removed. Adolescents who chose these longer-acting methods had higher rates of satisfaction than those choosing shorter-acting methods (such as the pill) and were 20 times less likely to experience an unintended pregnancy.[25]

See Eligibility section below for more information.

[24] ibid

[25] The Contraceptive Choice Project, http://www.choiceproject.wustl.edu

Improving Effective Contraceptive Use

This section includes strategies for Coordinated Care Organizations and providers to improve effective contraceptive use. Not all strategies will be appropriate or feasible for every setting: CCOs, clinics and providers should consider a mix of strategies to improve reproductive health that will best serve their populations and values.

Strategies 3 and 4 have been adapted from the work of Dr. Mark Hathaway, the Title X Medical Director at Unity Health Care, a federally qualified health center in Washington, D.C.[26]

Strategy 1: Screen women for their pregnancy intentions on a routine basis

Women should be given the opportunity to discuss their pregnancy intentions, that is, whether they want to have any or more children, and if so, the desired timing and spacing of those children. Clinicians can improve contraception uptake and method satisfaction by screening women for their pregnancy intentions.

CCOs could screen for pregnancy intentions as part of an initial health risk assessment or welcome call in order to connect women with timely preconception care or contraception services. If CCOs pursue this strategy, ensuring that any information on pregnancy intention or health risks are shared with the primary care provider is critical for care coordination.

Several pregnancy intention screening tools are available for use in clinical and non-clinical settings. However, Oregon has served as a national leader in this area with the One Key Question® initiative, developed by the Oregon Foundation for Reproductive Health. One Key Question® has the support of the American Academy of Family Physicians, the American Public Health Association, and the National Association of Nurse Practitioners in Women's Health. It has been endorsed by the Oregon Medical Association, the Oregon Nurses Association, the Oregon Primary Care Association, and many more.[27]

One Key Question® is the recommended approach for pregnancy intention screening in Oregon.

One Key Question® Initiative

The One Key Question® initiative encourages primary care providers to routinely ask women of reproductive age **"Would you like to become pregnant in the next year?"** The purpose of asking the question is to ensure that women who answer "yes" receive preconception care to improve the health of their pregnancy, and those women who answer "no" or "unsure" receive contraception care that meets their needs.

Pregnancy intention should be assessed within the primary care medical home and workflows for both "yes" and "no" responses will help ensure that the woman's wellness is addressed. Pilot studies of the

[26] http://www.arhp.org/uploaddocs/RH13_Presentation_Increasing_Long-Acting_Reversible_Contraception_LARC.pdf and http://www.healthypeople.gov/sites/default/files/Reproductive%20and%20Sexual%20Health.pdf

[27] www.onekeyquestion.org/endorsers/

One Key Question initiative indicate 30 – 40 percent of women screened for their pregnancy intentions needed follow-up care with contraception or preconception counseling.

Proactive conversation about reproductive health driven by the clinician or CCO instead of only in response to patient requests will likely increase the proportion of women who initiate contraception or switch to a more effective method. Investing in this model of assessment in primary care, including building One Key Question into electronic health records, will help build an infrastructure to support women receiving the right contraceptives in the context of the rest of her healthcare.

Implementing One Key Question®

When screening women for pregnancy intentions, it is important to keep the following in mind:

- Asking about pregnancy intentions is not the same as asking about the need for contraception. The conversation should be patient-centered, focusing on the woman's goals for her life, her family and values, and her worries, concerns, or beliefs about various forms of contraception.

  Be cautious about bias –providers may be surprised when learning the pregnancy intentions of patients who have been in their care for years.

- If a woman answers "yes", the provider can start the woman on folic acid and prenatal vitamins, and then schedule a follow-up visit for a more thorough assessment that includes chronic care conditions, medications, health practices for alcohol use and nutrition while not using effective contraception, and when to engage a specialist if pregnancy does not occur after six months. See Preconception Health section above.

- If a woman answers "unsure" or "would be okay either way", providers should offer her both contraceptive care and preconception care. When women express their ambivalence, providers can take this opportunity to assess satisfaction with their current contraceptive method and offer them a new method if they are interested.

- If a woman does not want to become pregnant, and is currently using contraception, it is important to ask her if she is satisfied with her method. If not, ask if she is interested in learning about other methods, particularly the most effective methods.

  The most appropriate form of contraception can change as a woman's life and relationship status changes. Routinely asking about her satisfaction with her method is key to determining if her current contraceptive method will be as effective as possible in preventing an unintended pregnancy.

Additional information on the One Key Question® initiative, including how to access the OKQ Implementation Manual, is available online at http://www.onekeyquestion.org/.

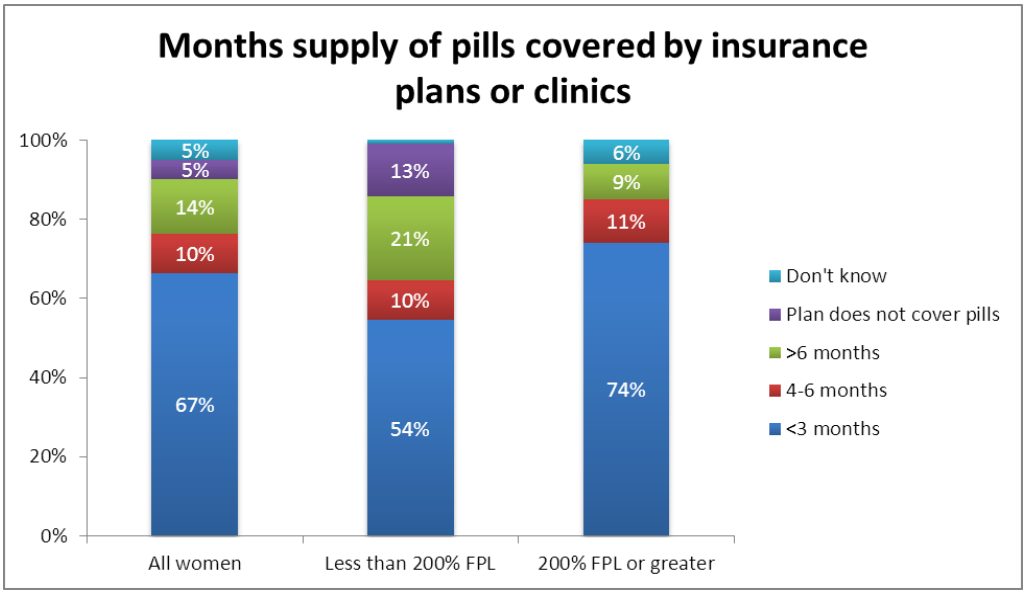
Free technical assistance for providers, clinics, and CCOss on all aspects of implementing One Key Question® is available upon request at info@onekeyquestion.org and 503.223.4510.

Strategy 2: Remove barriers to contraception

Provide contraceptive supplies for longer periods

Prescription hormonal contraception such as the pill, patch and ring can be difficult to use when limited supplies are dispensed and frequent refills are needed. Nationally, 28 percent of women who use oral contraceptives report that they have missed a pill because they could not receive the next pack on time. Knowing that lower-income women have additional barriers to accessing health care, such as lack of transportation and child care, too many women, especially in rural Oregon, may not be able to make it back to the clinic or pharmacy for refills. CCOs can choose to provide contraceptive supplies for longer periods of time, such as six months or a year.

Among women who have used oral contraceptives in the past year, nationally, 67 percent reported that their health plan or their clinic allows them to only receive 3 months' supply or less at a time.[28]



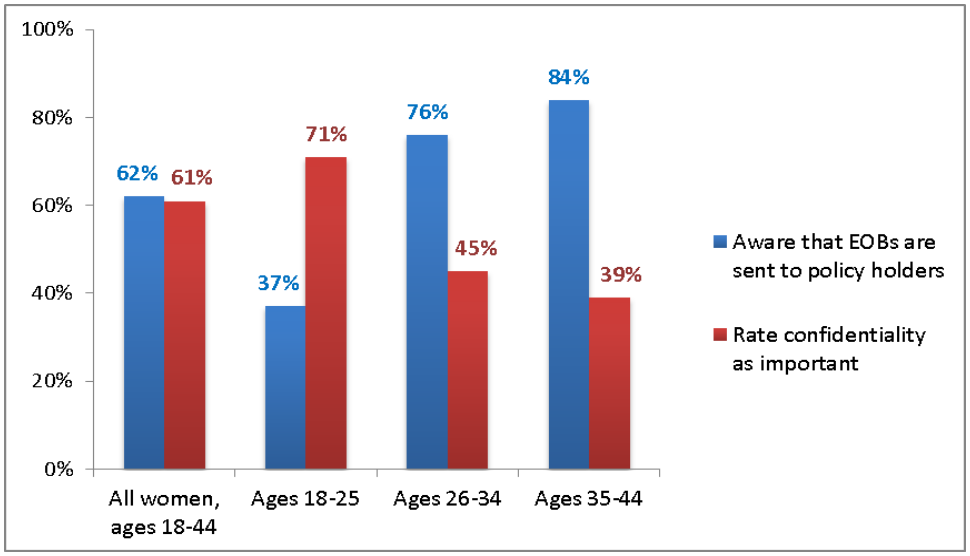
Kaiser Family Foundation, 2013 Kaiser Women's Health Survey. Among women ages 15-44 who have had sex within the past 12 months, have used birth control pills within the past 12 months. The Federal Poverty Level (FPL) was $19,530 for a family of three in 2013.

- Women who receive a one-year supply of contraceptive pills are 30 percent less likely to experience an unintended pregnancy compared to women who receive a one-month or a three-month supply.
- Long- term dispensing strategies were found to be cost-effective in California's Medicaid program, with the increased cost of contraceptive supplies being substantially less than the cost of the unintended pregnancies averted.[29]

[28] Women and Health Care in the Early Years of the Affordable Care Act: Key Findings from the 2013 Kaiser Women's Health Survey. Kaiser Family Foundation, May 2014. http://kaiserfamilyfoundation.files.wordpress.com/2014/05/8590-women-and-health-care-in-the-early-years-of-the-affordable-care-act.pdf

Improve confidentiality

Lack of confidentiality for services, due to Explanation of Benefits (EOB) being sent to members, is an important barrier to accessing contraceptive services for many women and adolescents. The 2013 Kaiser Women's Health Survey found that while young women value confidentiality, many were unaware that health plans can send EOBs to parents.



Kaiser Family Foundation, 2013 Kaiser Women's Health Survey. Includes women who are ages 18-25 and older women who are privately insured or are covered as a dependent. Important includes very and somewhat important.

CCOs can establish processes by which EOBs, or other confidential information on services and prescriptions, can be suppressed for specified sensitive services, or for any members requesting confidentiality, thereby supporting client wishes. Strategies to protect patient confidentiality, especially for adolescents and young adults, can be found in the policy brief Protecting Adolescent Confidentiality under Health Care Reform: the Special Case Regarding Explanation of Benefits (EOBs).[30]

Affect patient attitudes and knowledge about contraception

Coordinated Care Organizations and providers can also play a role in affecting patient attitudes and knowledge about contraception.

CCOs can:

- Establish sexual and reproductive health resources centers.
- Highlight the benefits of family planning (and lack of barriers to receiving family planning services) in patient materials, including handbooks and online.

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[29] Foster DG, et al. Number of oral contraceptive pill packages dispensed and subsequent unintended pregnancies. Obstetrics and Gynecology, 2011, 117(3): 566-72

[30] http://healthpolicy.ucsf.edu/sites/healthpolicy.ucsf.edu/files/documents/EOB%20Policy%20Brief_FINAL.pdf

- Conduct regular outreach to women of reproductive age to encourage them to come in for family planning visits, or highlight family planning visits as part of routine health care (such as adolescent well care or well women visits).
- Standardize patient education materials and make them available across the CCO's provider network.

Clinics can:

- Utilize educational materials, such as brochures, videos, demonstration models, websites, applications, etc.
- Discuss the benefits of family planning with patients and identify any remaining or perceived barriers as part of effective counseling. Women may not know what services are covered by Medicaid or under the Affordable Care Act.
- Discuss using condoms in addition to other contraceptive methods to help reduce the risk of sexually transmitted infections.

Increase postpartum contraceptive use

Postpartum women are at increased risk (10-44 percent) for unplanned pregnancy in the first year following delivery.[31] Non-breastfeeding women return to ovulation as early as three weeks postpartum: a postpartum visit occurring six weeks after delivery leaves women at risk of unintended pregnancy during this postpartum period.

Barriers to postpartum contraceptive use include provider advice against intrauterine devices, women missing their postpartum visits, limitations in insurance coverage, and repeat pregnancies.[32] One study found that 12 percent of women desired an IUD postpartum, but only 60 percent of these women were able to obtain the IUD. [33]

CCOs and providers can adopt the following strategies to increase postpartum contraceptive use:

- Provide effective contraception immediately after delivery; do not wait for the first postpartum visit. Intrauterine devices can be placed within 10-15 minutes of delivery of the placenta.

[31] Seehusen, D and Schmidt M. Contraceptive Education for Women after Childbirth. Am Fam Physician 2013 June 1;87(11):761-762. http://www.aafp.org/afp/2013/0601/p761.html

[32] Torres, L. Postpartum Contraception: Best Practices. Presentation at the 2014 Association of Reproductive Health Professionals conference http://www.arhp.org/uploaddocs/RH13_Presentation_Postpartum_Contraception.pdf

[33] Ogburn JA, et al. Barriers to intrauterine device insertion in postpartum women. Contraception. Dec 2005;72(6):426-429

- If unable to provide effective contraception immediately after delivery, schedule the first postpartum visit at 3 weeks, rather than 6 weeks.[34] Implement additional outreach or follow-up to ensure more women attend their postpartum visits.
- Educate providers on the importance and effectiveness of postpartum contraception. See strategy 4 above for additional information.
- Identify billing strategies for placement of IUDs and implants in inpatient settings.

Other barriers

Requiring other preventive screening tests (such as a pelvic exam or Pap smear) as a prerequisite to dispensing hormonal contraception is a barrier to contraceptive services.[35]

- Consider not requiring pelvic exams and Pap smears before dispensing refills on short-acting prescription methods.

Pelvic exams and Pap smears are still important preventive services; for some women, this may be the only opportunity providers have to perform these screenings. CCOs and clinics should carefully weigh the benefits and challenges when addressing this barrier.

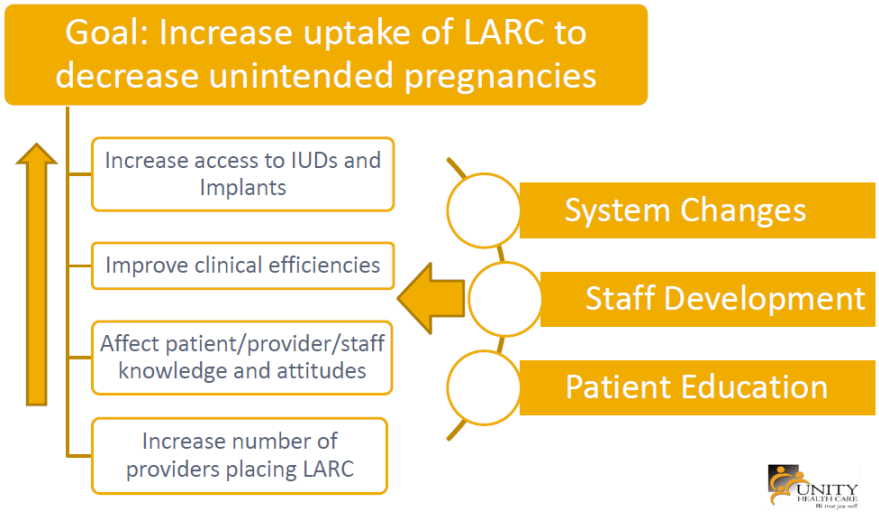
[34] Speroff L, Mishell DR, Jr. The postpartum visit: it's time for a change in order to optimally initiate contraception. Contraception. Aug 2008;78(2);90-98.

[35] Henderson JT, et al. Pelvic examinations and access to oral hormonal contraception. Obstet Gynecol. 2010 Dec;116(6):1257-64.

Strategy 3: Improve availability and uptake of long-acting reversible contraception (LARCs)

Long-acting reversible contraception (LARC) includes some of the most effective contraceptive methods available. Increasing the use of LARCs will improve effective contraceptive use across the Oregon Health Plan, but may require both systemic changes at the CCO and clinic level, as well as efforts to educate providers on clinical best practices and patients on their options. See Strategy 4 for provider-level strategies.

Unity Health Care Model for Increasing LARC Use



At the clinic

For clinics that are unable to provide IUDs and implants, it is important to connect members with providers that can. Family planning clinics have required proficiency and extensive experience dispensing all contraceptive methods, including LARCs. Family planning clinics may also be able to provide the quickest access to LARC services.

- Build collaborative relationships with local family planning clinics that have experience in rapidly dispensing contraceptive methods, including LARCs.

For clinics that are able to provide IUDs and implants, it is important to get everyone on board. Effective contraceptive use is not solely the responsibility of the clinician. Administrative and other support staff, health educators, and clinicians all have roles to play in supporting LARC adoption. Recommended strategies include:

- Create a dedicated family planning team or lead staff within the clinic to affect change.
- Integrate family planning into staff development initiatives, including new hire orientation.

All clinics can help increase the use of LARCs by making sure they have adequate inventory to meet needs.

- Plan for continual availability of contraception through the development of careful inventory systems, managing a ready stock by balancing ordering, dispensing, and redistributing to another site if needed.

At the Coordinated Care Organization

CCOs can provide strong leadership in support of LARCs by highlighting their effects on unintended pregnancy and their potential cost effectiveness and adopting policies and practices that support LARC uptake.

- Remove all barriers to IUDs, including denials, step therapy, or prior authorization requirements, to ensure they are available as first-line treatment for the prevention of unintended pregnancy.
- Leverage resources to help ensure continual availability of contraception across provider networks, such as wholesale purchasing of products for cost savings, researching best purchasing opportunities on behalf of clinics, supporting clinics in determining their purchasing needs based on use, or requiring uniform stocking of LARCs at high volume sites. Note: local family planning clinics may be able to share their experience with effective purchasing and stocking of contraception.
- Fund and host community clinical training for LARC methods, as training for these methods may be hard to find for providers after residency.
- Provide training on or clarify any coding and reimbursement concerns from clinics.

Strategy 4: Create quality improvement processes for contraceptive care

Quality improvement processes for contraceptive care can be developed at the CCO and/or clinic level. Helping women plan healthy pregnancies (and avoiding those that are unwanted or mistimed) is a core component of primary care. Providers and payers can work together to overcome the barriers to effective contraceptive use, reduce unintended pregnancies and improve health.

Monitoring

- CCOs and clinics can use administrative (claims and encounter) and/or electronic health record (EHR) data to track pregnancy intentions and contraceptive use as a core preventive service in primary care settings, similar to cancer screenings.
- CCOs can use administrative data to identify patterns and potential barriers in contraceptive use (e.g., are there clinics or areas within their network that are not using IUDs or implants?).
- Clinics can scrub charts to identify and reach out to patients in need of pregnancy intention screening and/or contraception services.

Workflows

- Clinics can identify and implement workflows to engage clinic staff in conducting screening for pregnancy intentions.
- CCOs and clinics can integrate One Key Question® pregnancy intention screening and family planning at all levels of care, including at primary care visit intake, at HIV/STI/pregnancy test visits, and at school-based health centers. Family planning can also be integrated into prenatal care visits to determine postpartum contraception plans before delivery.
- CCOs and clinics can ensure at least one provider at each clinic has space and time to initiate LARCs or develop processes to have a warm handoff to clinics where this contraception can be initiated.
- Clinics can promote patient follow-up, including scheduling recheck visits for LARCs at 6-8 weeks, and asking follow up questions about satisfaction with method and side effects, as well as addressing any primary care issues and STI counseling. Also ensure workflows for following up with women after any missed visits.

Training & Resources

- CCOs and clinics can ensure providers and clinic staff receive standardized training and develop skills in contraceptive counseling and the provision of contraception services. See Strategy 5 for additional information.
- CCOs can fund and host community clinical training for LARC methods, as training for these methods may be hard to find for providers after residency.

- CCOs and clinics can provide clinical reference tools, including demonstration models for LARCs and other job aids in exam rooms.
- CCOs and clinics can provide plain-language patient education materials and counseling sheets, in English and other languages.
- CCOs can identify a point person at the CCO to field questions and provide support to clinics and providers related to effective contraceptive use.
- CCOs can develop new communications or incorporate sexual and reproductive health updates into regular communications with providers and clinics and members.

Strategy 5: Build provider awareness and capacity around effective contraceptive use

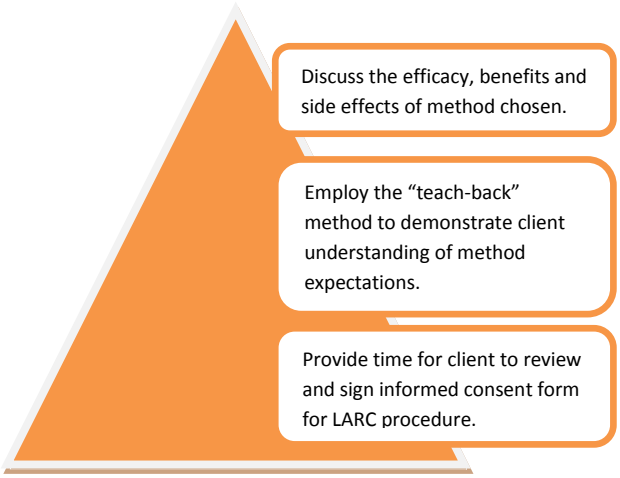
CCOs and providers can help ensure that primary care clinicians serving women of reproductive age are skilled in counseling women about all methods of contraception, even if they do not provide those methods themselves.

Many women are living in situations where their reproductive health is complicated by domestic violence, disabilities, or historic oppression. It is important for CCOs and providers to build respective, whole-person approaches to contraception care for these women, focusing on her goals for her life and her health, and supporting her decisions.

Providers and CCOs can work together to enhance providers' skills in providing IUDs and implants by attending LARC insertion trainings and participating in preceptorship opportunities. CCOs can support these efforts by sponsoring continuing education, fostering learning collaboratives, and promoting best practices.

Provide effective counseling

Effective counseling can be delivered in a three-prong approach, as defined by Unity Health Care as part of their initiative to increase LARC use:



1. **Discuss the efficacy, benefits, and side effects of method chosen**

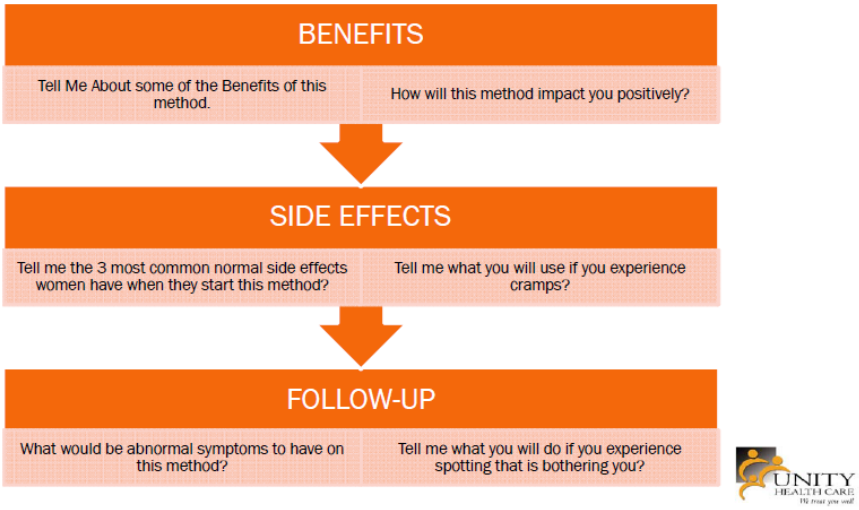
   Counseling should begin by asking about pregnancy intentions (see Strategy 1). Providers should also ask women about methods they are aware of, methods they have tried in the past, their likes and dislikes, and their current menstrual experiences.

   Counseling should be patient-focused and clear about the effectiveness of various methods, emphasizing Tier 1 methods (vasectomy and tubal ligation as permanent methods, IUDs and implants as long-acting reversible methods). Counseling should also cover the duration of use, hormonal versus non-hormonal methods, and barrier versus non-barrier methods.

All staff should be educated that most patients are LARC candidates. Counseling should include an explanation that LARC methods are safe and effective for nulliparous women (women who have never experienced a pregnancy), including adolescents.[36]

Optimal care includes providing same-day placement of LARC methods, to decrease the barrier of an additional visit, and providing information on the management of potential side effects. CCOs can support clinics by providing evidence-based best practices documents or other training materials for primary care providers in support of same-day placement, side effect management, and other considerations for LARC use.

2. **Employ the "teach-back" method, or other client-centered counseling model, to demonstrate client understanding of method expectations**



Research shows that 40 to 80 percent of medical information is forgotten by patients and half of the retained information is remembered inaccurately. Utilizing the teach-back method can increase the likelihood of patients following through on instructions by asking them to show or explain what they heard. Teach-back is one of the top 11 patient safety practices.[37]

Additional information and tools are available online from the Reproductive Health Program.[38]

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[36] Harper CC, Henderson JT, Raine TR, Goodman S, Darney PD, Thompson KM, Dehlendorf C, Speidel JJ. Evidence-based IUD practice: family physicians and obstetrician-gynecologists. Fam Med. 2012 Oct;44(9):637-45.

[37] Patient Education Update Newsletter: *Teach-Back – Is it your standard of practice yet?* Fran London, MS, RN, October 2012. http://www.patienteducationupdate.com/2012-10-01/article2.asp

[38] https://public.health.oregon.gov/HealthyPeopleFamilies/ReproductiveSexualHealth/Resources/Documents/Update_Newsletters/Update%20Attachments/2013/Counseling_Tool.pdf and http://public.health.oregon.gov/HealthyPeopleFamilies/ReproductiveSexualHealth/HealthEducation/Pages/Counseling-Tools.aspx

3. Provide time for client to review and sign informed consent form for LARC procedure

CCOs and clinics should ensure that all providers have an informed consent form and training, or a script for how to talk to a member in a way that promotes clear understanding by a woman of her choices and any risks involved.

Members should not be given forms to sign without discussion: patient participation in these decisions must be voluntary and they must be provided adequate, appropriate information to make decisions.[39]

[39] Guarding against coercion while ensuring access: a delicate balance. Guttmacher Policy Review, Summer 2014, Vol 17(3). http://www.guttmacher.org/pubs/gpr/17/3/gpr170308.html

Strategy 6: Enhance partnerships with local family planning clinics

While the Oregon Health Authority promotes the patient-centered primary care home model, it also values the principle of member choice. Many Medicaid members choose specialized family planning centers, including local county health departments, Planned Parenthood clinics, and local community health centers, for their reproductive health needs. These centers are often perceived as respectful, confidential, timely, affordable, and of high-quality care. [40]

Because primary care providers may have limited capacity for new clients, and because members may prefer family planning centers, it is important for CCOs to partner with local family planning providers. These canters can provide same-day, and often, walk-in access to contraceptive methods starts, emergency contraception, and STI services, as well as onsite dispensing of contraceptive methods.

Family planning clinics are the entry point to, and often the only source of, regular medical care for many women and adolescents, including screenings for breast and cervical cancer, diabetes, blood pressure, and cholesterol.

Contracting with family planning clinics

Coordinated Care Organizations can contract with family planning clinics to ensure that women have access to experienced providers of family planning services, reproductive health and related preventive services.

CCOs should consider including the following in contracts with family planning clinics:

- Mechanisms for the coordination of care, including two-way formal referral agreements between the family planning clinic and primary care provider. For example, it may be most efficient for family planning clinics to provide method starts for clients in need of quick access to contraception, and then for the client to be referred back to the primary care provider for annual or well-women exams, or other health concerns.

- Processes to ensure client confidentiality (e.g., suppression of Explanation of Benefits) when services are billed by the family planning clinic to the CCO.

- Appropriate reimbursement for contraceptive service provided. Although family planning services billed to MAP FFS by family planning clinics will be attributed to the member's CCO regardless of contract status, it is possible that such services will not count toward the incentive measure in 2016.

- Reimbursement for the full scope of services provided at family planning clinics (including STI testing and treatment, immunization services, counseling services, adolescent well visits, etc).

[40] Gold RB, Besieged Family Planning Network Plays Pivotal Role, *Guttmacher Policy Review*, 2013, 16(1): 13-18.

CCO Incentive Measure

The Metrics & Scoring Committee selected "Effective Contraceptive Use" or ECU as a CCO incentive measure for the third measurement year, 2015.

Measure Specifications

OHA developed measure specifications based on national specifications under review with the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare and Medicaid Services (CMS), and in collaboration with the Oregon Preventive Reproductive Health Advisory Council (OPHRAC) and the Metrics Technical Advisory Workgroup (TAG).

The Effective Contraceptive Use measure looks at adult (ages 18-50) and adolescent (ages 15-17) women with evidence of one of the most effective or moderately effective contraceptive methods during the measurement year. OHA will report on both adults and adolescents, but CCOs will only be incentivized for the adult (ages 18-50) population.

While the Oregon Health Authority is incentivizing effective contraceptive use, it is important to remember that Oregon Health Plan clients must be free to choose the method of family planning that is to be used. Per federal law, health plans must provide that each member is "free from coercion or mental pressure, and free to choose the method of family planning to be used."[41]

Numerator: Women in the denominator with evidence of one of the following methods of contraception during the measurement period (calendar year):

- Sterilization;
- intrauterine device;
- implant;
- contraception injection;
- contraceptive pills;
- patch;
- ring; or
- diaphragm.

See the detailed measure specifications online at http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx for the full list of procedure, diagnosis, and pharmacy codes that count towards the numerator.

Denominator: All women ages 15-50 as of December 31 of the measurement year who were continuously enrolled in a CCO for the 12-month measurement period. Women who were pregnant during the measurement year or who are unable to become pregnant are excluded from the measure.

[41] See 42 CFR § 441.20

Note: OHA will be measuring and reporting on adolescent and adult women separately, by ages 15-17 and ages 18-50. Only the adult rate will be tied to the CCO's incentive payment.

Measurement period: The measurement period is the calendar year, January – December.

Data source: The data source for the measure is administrative data within MMIS, including claims and pharmacy records. This measure will not require medical record review or include supplemental information from electronic health records.

FAQ

Which women are excluded from the measure?

Women who are not at risk of unintended pregnancy due to hysterectomy, bilateral oophorectomy, and natural or premature menopause are excluded from the measure. Women who are currently pregnant or were pregnant during the measurement year are also excluded.

Note that women whose partner has had a vasectomy, women who are not currently sexually active, women who are actively trying to become pregnant, and women who do not have sex with men are not excluded from the measure. However these women do not count against CCO performance on the measure. The benchmark was set deliberately low enough to account for the percentage of these women out of the total population of women of reproductive age.

What about women who were pregnant during the measurement year, but received postpartum contraception?

These women will be included in the measure; the specifications look first for all evidence of contraception and then apply the pregnancy exclusion.

Women who are pregnant or were pregnant during the measurement year do not count against the CCO's effective contraceptive use rate, but women who were pregnant during the measurement year and received postpartum contraception will be included in the numerator and count toward the CCO incentive measure.

How does the measure count women who are using a long-term contraceptive or permanent method, that may not have been placed or billed for during the measurement year?

The measure is only looking for codes during the measurement period; no look back periods are applied to identify procedures or services occurring in previous years. However, a number of surveillance codes are included in the specifications to account for women utilizing long-acting reversible contraceptives or permanent contraceptive options who would not otherwise have a procedure code or pharmacy claim during the measurement period.

Examples of these surveillance codes include:

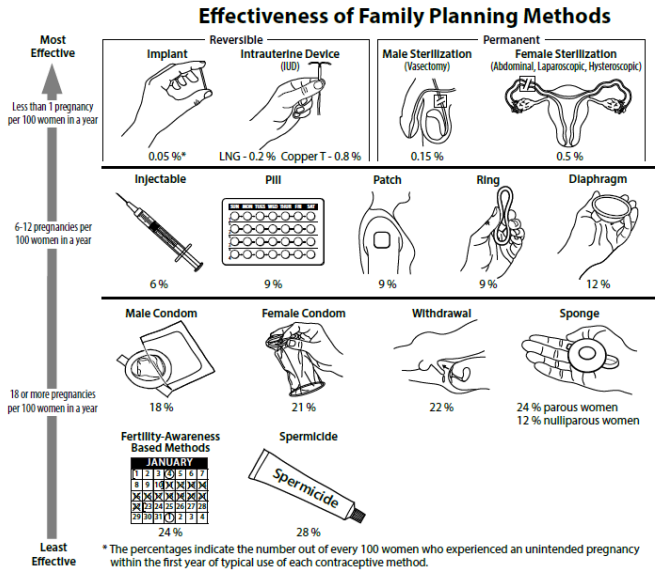
- V25.42, surveillance of previously prescribed contraceptive method, intrauterine device.
- V25.43, surveillance of previously prescribed contraceptive method, implantable sub-dermal contraceptive.

The measure also excludes women who have had a prior tubal ligation or hysterectomy. Women who were sterilized during the measurement year are counted towards the measure.

See the specifications posted online at http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx (see CCO Incentive Measure Specification Sheets section) for the full list of surveillance codes.

What about women who received a long-term contraceptive prior to Medicaid enrollment?
See above. The measure is only looking for codes during the measurement periods, and surveillance codes can be used to account for these women.

What contraceptive methods are included in the CCO incentive measure?
The measure only includes the most effective and moderately effective contraceptive methods (Tier 1 and Tier 2). This includes tubal ligation, intrauterine devices, implants, pills, patches, rings, injections, or diaphragms.



Adapted from WHO's Family Planning: A Global Handbook for Providers (2001) and Trussel et al (2011).

Does the measure only count long-acting reversible contraceptives (LARCs?)
No. The CCO incentive measure includes LARCs and all methods listed as either Tier 1 or Tier 2 (see graph above).

What about women who are using another method of contraception?
Less effective methods, such as male and female condoms, fertility-awareness based methods, spermicides, sponges, and withdrawal will not count toward the CCO incentive measure.

Is male sterilization included in the CCO incentive measure?
No. While male sterilization is a Tier 1 (most effective) method of contraception, the CCO incentive measure is based on women. There is no reliable way to connect women in the denominator with men who have been sterilized.

Even if there is administrative data for the woman that indicates the contraceptive method she uses is male sterilization, it cannot be determined from administrative data if the woman changes partners, or has multiple partners, and therefore she should still be considered 'at risk'.

What about men? Shouldn't they be involved in family planning?
Absolutely. It is a great idea to talk to men about their intentions for parenting and how it fits in with their life goals. Providers can ask them what they know about their partner's method of contraception, how it works and how effective it is.

My clinic already offers contraception services to patients who request it. How are we supposed to improve performance on this measure?
You can improve performance by routinely screening women of reproductive age for their pregnancy intentions. This will help you to find women who do not want to become pregnant but either are not using any contraception or are unhappy with their method.

Many women in our CCO receive family planning services through the county health department or a Planned Parenthood clinic. Will these services count toward the measure?
Yes. For the 2015 CCO incentive measure, as long as there is a Medicaid claim for effective contraception (see specifications) for a member, the CCO will receive credit for that service in the measure whether or not the service was provided through the health plan or billed directly to the state Medical Assistance Program (MAP) as Fee For Service (FFS).

In 2015, OHA plans to provide CCOs with reports showing effective contraceptive use provided through FFS billing separately from effective contraceptive use provided through the CCO. This will enable better understanding of where Oregon Health Plan women are receiving services and identify potential areas for collaboration or contracting.

Note that in 2016, contraceptive services billed directly to the MAP as FFS may not count toward the incentive measure. CCOs are encouraged to work closely with local family planning clinics to ensure correct billing for those clinics already contracted with the CCO, and to develop partnerships or contracts with those clinics not already contracted. See Strategy 6 above.

Finally, be cautious about assuming that many or most women receive their care at family planning clinics; most women prefer to receive this care with their primary care provider. When you do have a strong family planning partner in your community, build partnerships or collaborative agreements with them so that women can receive the contraceptive method they choose quickly and efficiently.

Eligibility

Effective contraceptive methods are a benefit available to most Medicaid enrolled women. Family planning services are not covered for women eligible under the Citizen/Alien-Waived Emergency Medical (CAWEM) benefit.

Covered Services

Reproductive health services are Line 6 on the January 1, 2015 Prioritized List of Health Services.[42]

The Oregon Health Plan covers the following services for men, women, and adolescents:

- Family planning visits (physical exams and contraceptive education)
- Contraceptive supplies, such as oral contraceptives and condoms
- Sterilization services (tubal ligations and vasectomies)

Additional covered services may include lab tests, radiology services, and emergency contraception.

Coordinated care organizations have some flexibility in determining the implementation of family planning benefits, within certain parameters. For example:

- Coordinated care organizations can require the use of generic pharmaceuticals above brand name products (ORS 414.325);
- CCOs may implement prior authorizations for family planning services, but only for preferred versus non-preferred products.
- CCOs can determine the number of days or months of contraceptives that are authorized. Note Medicaid FFS allows a 100-day supply of contraceptives because it reduces the dispensing fee and has a minimal fiscal impact, compared to the risk of unintended pregnancy.

Co-Payments

OAR 410-120-1230 and 42 CFR 447.53 / CFR 447.62 -447.78 require family planning and related services or supplies for Oregon Health Plan members to be provided with no co-payment or deductible.

Service Providers

Under Oregon Administrative Rule 410-130-0585(4) CCO members can receive family planning services outside of the CCO's network, via a county health department, a family planning clinic, or any other provider who will accept OHP.

[42] http://www.oregon.gov/oha/healthplan/pages/priorlist.aspx

Family planning services received outside of the CCO's network are billed to the state directly as Fee For Service. See Strategy 6 above. Under OAR 410-120-1855 and 410-141-3320 CCO members and Fee For Service (open card) clients do not need a referral from a primary care provider or primary care manager to obtain family planning services.

Billing & Reimbursement

It is the responsibility of each provider to select the most appropriate diagnosis and procedure codes when billing for services. It is the provider's responsibility to comply with the CCO's prior authorization requirements or other policies necessary for reimbursement, before providing services to any Medicaid client enrolled in a CCO. It is the provider's responsibility to be compliant with federal and state laws (see OAR 410-120-1160).

Providers in family planning clinics outside of the CCO's network must also comply with state rules related to the provision of family planning services in family planning clinics per OAR 410-130-0587.

For More Information

For questions related to the CCO incentive measure, please contact the Office of Health Analytics at Metrics.Questions@state.or.us

For questions related to publically funded family planning clinics, please contact the Oregon Reproductive Health Program at 971.673.0355 or visit healthoregon.org/fp.

For questions related to the One Key Question® initiative, please contact Michele Stranger Hunter, Executive Director of Oregon Foundation for Reproductive Health at 503.223.4510.

For questions related to Medicaid billing, please contact Provider Services at 1.800.336.6016.

Resources

Guidelines

U.S. Medical Eligibility Criteria for Contraceptive Use (MEC), 2010

The MEC is intended to assist health care providers when counseling women, men, and couples about contraceptive method choice. The MEC provides guidance on the safety of contraceptive method use for women with specific characteristics and medical conditions.

- MEC: http://www.cdc.gov/reproductivehealth/UnintendedPregnancy/USMEC.htm
- 2012 update: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6124a4.htm?s_cid=mm6124a4_e%0d%0a
- Provider training: http://www.cdc.gov/reproductivehealth/UnintendedPregnancy/USMECTraining.html
- Understanding and using the MEC, ACOG: http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Gynecologic-Practice/Understanding-and-Using-the-US-Medical-Eligibility-Criteria-for-Contraceptive-Use-2010

U.S. Selected Practice Recommendations for Contraceptive Use (SPR), 2013

The SPR provides guidance on how contraceptive methods can be used and how to remove unnecessary barriers for patients in accessing and successfully using contraceptive methods. The SPR includes recommendations on when women can start contraceptive methods, what exams and tests are needed before starting a method, what follow-up is appropriate, and how to address side effects and other problems with contraceptive method use.

- SPR: http://www.cdc.gov/reproductivehealth/UnintendedPregnancy/USSPR.htm
- Understanding and using the SPR, ACOG: http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Gynecologic-Practice/Understanding-and-Using-the-US-Selected-Practice-Recommendations-for-Contraceptive-Use-2013

Providing Quality Family Planning Services: Recommendations of the CDC and the U.S. Office of Population Affairs

This 2014 report provides recommendations developed collaboratively by CDC and the Office of Population Affairs (OPA) of the U.S. Department of Health and Human Services (HHS). The recommendations outline how to provide quality family planning services, which include contraceptive services, pregnancy testing and counseling, helping clients achieve pregnancy, basic infertility services,

preconception health services, and sexually transmitted disease services. The primary audience for this report is all current or potential providers of family planning services, including those working in service sites that are dedicated to family planning service delivery as well as private and public providers of more comprehensive primary care.

- QFP: http://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf

Initiatives

One Key Question

The One Key Question initiative is the Oregon Foundation for Reproductive Health's solution to making Oregon women and families healthier and ensuring that more pregnancies are wanted, planned, and as healthy as possible. Consultation on one key question implementation and preventive reproductive health care, trainings for primary care teams, and technical assistance is available upon request. Patient and provider resources are posted online at http://www.onekeyquestion.org/.

Reproductive Health Access Project

The Reproductive Health Access Project seeks to ensure that women and adolescents at every socioeconomic level can readily obtain birth control and abortion from their own primary care clinician. Through training, advocacy and mentoring programs, the Project helps family physicians and other clinicians make birth control and abortion part of routine medical care.

Contraceptive resources, including guidelines, patient education materials, forms, teaching tools, and more available online at http://www.reproductiveaccess.org/contraception/index.htm

Bedsider Birth Control Support Network

Bedsider is an online birth control support network for women 18-29 operated by The National Campaign to Prevent Teen and Unplanned Pregnancy, a private non-profit organization. Resources include free patient handouts, reminder systems, and more. http://providers.bedsider.org/

Training and Technical Assistance

OHSU Family Planning Fellowship

For immediate physician consultation for contraception questions, including appropriate methods for complex patients and managing side effects, call 1.800.245.6478 (ask for the Family Planning physician to be paged).

Family Planning National Training Centers: Clinical Training Center

The National Clinical Training Center (CTC) for Family Planning provides quality clinical training in support of clinical family planning Nurse Practitioners, Certified Nurse Midwives, Physicians, and Physician Assistants. This includes a national family planning training symposium, national reproductive health conference, and clinical webinars. http://www.ctcfp.org

Professional Organizations

Association of Reproductive Health Professionals

- Clinical fact sheets: https://www.arhp.org/publications-and-resources/clinical-fact-sheets
- Reference guides for clinicians: https://www.arhp.org/publications-and-resources/quick-reference-guide-for-clinicians
- Clinical practice tools: https://www.arhp.org/publications-and-resources/clinical-practice-tools
- Patient resources (handouts and interactive online tools): https://www.arhp.org/publications-and-resources/patient-resources

American Congress of Obstetricians and Gynecologists

- ACOG's LARC Program (clinical guidance, educational materials, continuing education, etc…): http://www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception
- Practice bulletins, committee opinion briefs, video series, patient education materials (English and Spanish): http://www.acog.org/Womens-Health/Birth-Control-Contraception
- Guidelines for adolescent health care

Toolkits

You Decide: Making Informed Health Choices about Hormonal Contraception

Designed to help health care providers better understand and speak to the risks and benefits of hormonal contraception. This toolkit is part of a comprehensive education program created by Planned Parenthood Federation of American and the Association of Reproductive Health Professionals. https://www.arhp.org/publications-and-resources/clinical-practice-tools/you-decide

Before, Between & Beyond Pregnancy: The National Preconception Curriculum and Resources Guide for Clinicians

The National Preconception / Interconception Care Clinical Toolkit was designed to help primary care providers, their colleagues, and their practices incorporate preconception health into the routine care of women of reproductive age. http://beforeandbeyond.org/toolkit

LARC FIRST

This toolkit was developed out of the Contraceptive Choice Project to help primary care and family planning clinics achieve a 'LARC FIRST Practice' by reducing barriers related to affordability, education, access, and staffing. http://www.larcfirst.com

General Reading

Contraceptive information from the Centers for Disease Control and Prevention
http://www.cdc.gov/reproductivehealth/unintendedpregnancy/contraception.htm

Contraception CHOICE Project: the study on removing barriers to LARCs and improving LARC update.
www.choiceproject.wustl.edu

Contraceptive Technology, 20th edition. For clinical information on the provision of contraception care.
http://www.contraceptivetechnology.org/the-book/